EXHIBIT A

8900000198034 048-1197-8 LC0127434 $120.10

truSTAGE®

APPLICATION FOR TruStage Individual Term Life Insurance to Age 80

CMFG Life Insurance Company
P.O. Box 61, 2000 Heritage Way
Waverly, IA 50677-0061
1-888-787-8243 or visit TruStage.com

APPLICANT COVERAGE

Jeffery D Lawhon

3350 A Hollands Branch Rd

Barboursville WV 25504

Primary phone (304) 707-7478

Email address glawhon1968@gmail.com

Date of birth REDACT Gender ☒ Male ☐ Female

Social Security Number REDACT

Will the coverage applied for replace, discontinue, or change any existing life coverage or annuities in this or any other company?

☐ Yes - company name and policy no.

☒ No

Select the amount of Term Coverage

☒ $70,000

BENEFICIARY INFORMATION

Beneficiary Name(s)	Relationship to You
Amy J Nicholas	Friend

HEALTH INFORMATION

Please answer these questions

1) Are you unable to work or perform normal activities due to a chronic illness or permanent injury? ☐ YES ☒ NO

2) Have you, within the past 5 years, been treated for or diagnosed by a medical professional with the following: (check all that apply) ☒ YES ☐ NO

☐ HIV, AIDS or AIDS-Related Complex	☐ Cancer (except basal cell)	☒ Heart Disease/Condition (except high blood pressure)
☐ Diabetes Requiring Insulin	☐ Stroke	☐ Chronic Disorder of the Brain or Spinal Nerve
☐ Alcohol or Drug Abuse	☐ Chronic Liver Disease	☐ Chronic Kidney Disease
☐ Chronic Depression	☐ Mental Disorder	☐ Chronic Lung Condition

IMPORTANT COMPLETE OTHER SIDE

ICC16-A10f-039
SIT-1508469.1-W

IST8016-C1

Approval is based upon your health and other factors affecting your insurability.

PAYMENT

Deduct
- ☒ Monthly
- ☐ Quarterly
- ☐ Semi-annually
- ☐ Annually

Option 1* Deduct from my
- ☒ Checking Account
- ☐ Savings Account

Routing # REDAC

Account # REDACTED

Financial institution name FIRST PRIORITY FEDERAL CREDIT UNION

Option 2* Deduct from my
- ☐ Credit/Debit Card (MC/VISA/Discover Only)

Account # _____ Expiration date _____

Name of card holder _____

Special remarks _____

*I authorize by signing below, CMFG Life Insurance Company to deduct premiums from the account I've selected for the life coverage applied for on this application. This authorization will remain in effect until revoked by me in writing or by phone.

If you leave this section blank, you will receive a bill.

Option 3
- ☐ Please send me a bill.

AGREEMENT

I authorize by signing below, that all my statements and answers are true to the best of my knowledge and belief. This application and any supplemental application(s) will be the basis of any insurance issued. I understand that: (1) benefits may be denied during the first 2 years from the effective date if I fail to give true and complete answers in this application, as described in the incontestability provision of the policy; and (2) this insurance becomes effective only if: a.) my application is approved and a policy issued; b.) my first full premium due is received while I am alive and within 21 days of my policy's effective date; and c.) the answers to questions concerning my insurability are as stated in this application.

I authorize any pharmacy benefit manager or other pharmaceutical firm having information about my prescription drug records to give all information to CMFG Life Insurance Company ("Company") to determine eligibility for insurance or benefits. Information obtained will be released only to persons performing business duties as delegated or contracted for by the Company related to my application and subsequent insurance-related functions, as permitted or required by law, or as I further authorize. The health information shared for these purposes is not subject to federal health information privacy laws; however state privacy laws do apply.

I agree this authorization is valid for 24 months or such time limit as provided by applicable state law, a copy is as valid as the original, and I or my authorized representative can receive a copy upon request. For purposes of collecting information in connection with a claim for benefits, this Authorization is valid for the duration of the claim.

I understand that: (1) I can revoke this authorization at any time by written request to the Company; (2) revocation of this authorization will not affect any prior action taken by the Company in reliance upon this authorization; and (3) failure to sign, or revocation of this authorization may impair the Company's ability to evaluate claims or process applications and may be a basis for denying this application or a claim for benefits.

SIGNATURE

Required Signature and Date Signed Authorizes Payment and Agreement

X Jeffery d Lawhon 02/14/2018

Applicant's Signature Date Signed

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit, or knowingly presents false information in an application for insurance may be guilty of a crime and subject to fines and confinement in prison, and denial of insurance benefits, depending on state law.

QUESTIONS? CALL TOLL-FREE

1-888-787-8243

TruStage.com

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